Milford Recreation Department **Summer 2014**
1 Union Square ~ Milford, NH 03055
Phone (603) 249-0625 ~ Fax (603) 673-2273

2014 *Keyes Pool*
Day Pass

As part of your Day Pass, you will gain access to Keyes Memorial Pool in Milford for open swim. Please sign the following Day Pass to safely enjoy access to the Keyes Pool facility during the scheduled hours. Due to the nature of an outdoor facility we are unable to provide refunds.

Monday – Friday - 12:30 - 7:00 PM

Weekends – 12:00 - 7:00 PM

Date of Use: _____

Staff Approval:_____

Please check one:
Please complete:

Residents - $5.00 _____

Non-Residents - $5.00 _____

**Free for children 4 and under and senior citizens 62+*

Member Name -_____ *(Optional)*

Guest Names - _____

_____

_____

_____

Checks made payable to "Milford Recreation Dept."
Returned check fee is $25

Street - _____

City, Zip - _____

Emergency Contact Name:_____ **Relation**:_____ **Phone**:_____

PERMISSION, EMERGENCY TREATMENT & WAIVER AGREEMENT:

I AM AWARE OF the hazards of the activity/sport and the risk of injury in this athletic program/facility. I certify that I am in good physical condition and am able to safely participate in this physical activity/sport.
I HEREBY GIVE MY PERMISSION for my son/daughter or child under my guardianship to use the pool facilities provided by the Town of Milford Recreation Department. I am aware of the hazards of pool activity and the risk of injury. I assume all risks and hazards incidental to such participation, and I do hereby waive, release indemnify, and agree to hold harmless the said Town of Milford, its volunteers, staff and all sponsors for all liability for any and all loss or damage, and any claim arising out of injury to my son/daughter or property damage that might occur, whether caused by negligence of the Town, agents or employees, or during participation.
IN CASE OF EMERGENCY, I hereby give my permission to the program staff and medical personnel selected by the Recreation Dept. and staff, in my absence, to act as my agent to apply simple first aid when necessary, or in the event of a more serious accident, for my child or child under my guardianship to be transported to an emergency medical facility to receive emergency medical treatment. I also authorize the medical personnel to administer such treatment as is medically necessary and I authorize the hospital to undertake examination and emergency treatment, if warranted, on behalf of my child. IN THE EVENT OF AN EMERGENCY, EVERY EFFORT WILL BE MADE TO CONTACT PARENT/GUARDIAN.

PLEASE LIST ALL MEDICAL CONCERNS or instructions the staff should know regarding your or your child's health on the back of this sheet (medications, allergies, behavior concerns, etc.)

Family Insurance Yes_____ No_____ Company Name_____

Participant Signature – (Parent/Guardian must sign if participant is under 18):

_____ Date_____